

EQUALITY AND HEALTH

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The treatment accorded Negroes by southern medical facilities—general hospitals, custodial institutions, health centers, nursing homes, clinics—reflects a striking contradiction between law and practice, a variance which exemplifies the historic method of accommodating Negro claims to equality: incorporation of egalitarian principles in legal norms, and administrative tolerance of actual inequality.¹ From Reconstruction, those desiring to improve the status of the Negro have sought to create an arsenal of civil rights and attendant remedies enforceable by federal power. Congressional action, however, has not always produced expected change. No doubt this is partially a consequence of limitations inherent in particular legislative formulations. Exclusion of Negroes from jury service, for example, has been prohibited by federal law since 1875,² but the persons responsible for the enforcement of this provision apparently consider it useless.³ Title VII of the Civil Rights Act of 1964, prohibiting racial and other discrimination in employment, was crippled by amendments supposedly necessary to obtain Senate approval.⁴ It would not be accurate, however, to ascribe the failure of civil rights legislation to achieve stated objectives solely to inherent defects or, for that matter, to resistance encountered from those hostile to the new rights. In order to discover the roots of continued resistance to legislatively endorsed goals, attention has shifted to focus on administration and the extent to which federal bureaucrats have taken an unduly restrictive view of their power and responsibility to end racial discrimination. This administrative tolerance of legislatively proscribed discrimination has

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¹ The tradition found its quintessential expression in the School Desegregation Cases where desegregation "with all deliberate speed," justified in the second case, *Brown v. Board of Educ.*, 349 U.S. 294 (1955), because of transitional administrative problems, served to accommodate the opponents of the first case, *Brown v. Board of Educ.*, 347 U.S. 483 (1954), by delaying significant nonracial pupil and teacher assignment for at least a generation.

² 18 U.S.C. § 243 (1964). The only recorded use of the statute is described in *Ex parte Virginia*, 100 U.S. 339 (1880).

³ 5 U.S. COMM'N ON CIVIL RIGHTS ANN. REP. 95-103 (1961).

⁴ 78 Stat. 253 (1964), 42 U.S.C. §§ 2000e to e-15 (1964); see Berg, *Equal Employment Opportunity Under the Civil Rights Act of 1964*, 31 BROOKLYN L. REV. 62, 68 (1964); Rosen, *The Law and Racial Discrimination in Employment*, 53 CALIF. L. REV. 729 (1965).

serious consequences.⁵ Unfortunately, public scrutiny is often stifled by the low visibility of administrative decision-making. Uncertainty as to what has and has not been accomplished blocks intelligent discussion and planning. This article attempts to set forth the records of the Department of Health, Education and Welfare and the Department of Justice with respect to their obligations to eliminate racial discrimination in governmental and publicly assisted medical facilities.⁶ Although the character of this response is a matter which has received coverage in the press and is much discussed at conferences between departmental representatives and civil rights groups, systematic treatment and comparison with nongovernmental desegregation efforts is desirable.

The constitutional and statutory obligation of the federal government to eliminate racial discrimination in provision of medical facilities and services is clear. Appellate courts have found racial discrimination by governmentally owned, operated or subsidized hospitals to violate the due process clause of the fifth amendment and the equal protection clause of the fourteenth amendment.⁷ Title VI of the Civil Rights Act of 1964 prohibits racial exclusion from participation, denial of benefits or discrimination "under any program or activity receiving federal financial assistance" and delegates to federal administrators ample power to enforce racial equality by refusal, withdrawal or termination of funds or by litigation.⁸ Title III of the Civil Rights Act empowers

⁵ It is apparent that tolerance of a wide gap between legal and behavioral norms fosters a corrosive cynicism among Negroes. Paradoxically, it also produces a subtle form of racism among whites. Told that Negroes have obtained legal rights to full equality, some explain continued de facto inequality in terms of the Negro's capacity or interest rather than as the product of discrimination and poverty. Once the faulty premise is accepted, hostility to expressions of Negro frustration is the result, a response which itself is likely to increase Negro frustration.

⁶ During the debate in the Senate on the Civil Rights Act of 1964, Senator Humphrey stated:

"Some Federal agencies appear to have been reluctant to act in this area. Title VI will require them to act. Its enactment will thus serve to insure uniformity and permanence to the nondiscrimination policy."

That is my view. So it is my view that the Department of Health, Education and Welfare should clarify its former ambivalence in this connection and its ambiguity of statement and policy and should make sure that the precise language here set forth—and the language of Title VI is precise—is adhered to.

110 CONG. REC. 12720 (1964).

⁷ *Simkins v. Moses H. Cone Memorial Hosp.*, 323 F.2d 959 (4th Cir. 1963), cert. denied, 376 U.S. 938 (1964). Although denial of certiorari is not usually accorded weight as precedent, it is evident that the failure to review *Simkins* is of more than usual significance, for, by refusing to grant certiorari, the Court upheld a declaration of the unconstitutionality of an act of Congress. See also *Flagler Hosp., Inc. v. Hayling*, 344 F.2d 950 (5th Cir. 1965); cf. *Smith v. Holiday Inns of America, Inc.*, 336 F.2d 630 (6th Cir. 1963).

⁸ 78 Stat. 252 (1964), 42 U.S.C. §§ 2000d to d-4 (1964); 45 C.F.R. §§ 80.1-80.13 (Supp. 1966).

the Attorney General to bring suit to enjoin discrimination at public facilities owned or operated by state governments.⁹ Title IX authorizes him to intervene in suits seeking relief from denial of equal protection of the laws.¹⁰ Even the discriminators with whom we are concerned primarily—southern medical facilities—have relinquished such rights as they might assert to distinguish racially by executing agreements with federal officers in which they pledge to eliminate racial discrimination as a condition of receipt of federal funds, an agreement which may be enforced by the United States in its courts.¹¹

A visitor to our shores, informed of these principles, would be forgiven surprise at the distance practice lagged behind. Those who cannot claim ignorance may only conclude dismally that in race relations, law is a poor index of behavior. Despite the clarity of federal law, thousands of medical facilities in southern and border states segregate or exclude Negro patients, physicians and nurses or provide them services and facilities inferior to those available to whites.¹² Although the form varies from community to community, often from hospital to hospital, disparity of treatment is as much a part of southern custom in medical facilities as in schools; the variety of racial distinctions encountered confirms the pervasiveness, if not the consistency, of Jim Crow.¹³

When southern hospitals construct or modernize health facilities the old building or portion of the building conventionally becomes a restricted area.¹⁴ Where a building or floor is shared, a hospital may maintain separate wards, private or semi-private rooms, lavatories, eating facilities, entrance ways, emergency rooms, maternity wards or nurseries. Some hospitals provide one ambulance service for whites, another for Negroes; others schedule out-patient clinics on "Negro"

⁹ 78 Stat. 246 (1964), 42 U.S.C. § 2000b (1964).

¹⁰ 78 Stat. 266 (1964), 42 U.S.C. § 2000h-2 (1964).

¹¹ 45 C.F.R. § 80.4 (Supp. 1966). The required assurances may be found at 9 RACE REL. L. REP. 1960 (1964).

¹² While discrimination in health facilities is most noticeable in the South, it is, like other varieties of racial discrimination, demonstrably present in many northern and western communities. See *Morris v. Chicago Hosp. Council*, 9 RACE REL. L. REP. 1838 (1964); NATIONAL URBAN LEAGUE, HEALTH CARE AND THE NEGRO POPULATION (1965); NEW YORK STATE ADVISORY COMM. TO THE U.S. COMM'N ON CIVIL RIGHTS, REPORT ON BUFFALO: HEALTH FACILITIES (1964); NEW YORK STATE ADVISORY COMM. TO THE U.S. COMM'N ON CIVIL RIGHTS, REPORT ON NEW YORK CITY: HEALTH FACILITIES (1964).

¹³ Many southern states have required segregation in state mental hospitals and sanitariums. GREENBERG, RACE RELATIONS AND AMERICAN LAW 373 (1959); MURRAY, STATES' LAWS ON RACE AND COLOR *passim* (1951). Segregation in nongovernmental hospitals, however, has been more a matter of custom than statutory command.

¹⁴ The textual description of patterns of discrimination found in southern hospitals is based on complaints filed with the Secretary of Health, Education and Welfare by the NAACP Legal Defense and Educational Fund, Inc., and the NAACP.

and "white" days or rigidly segregate thermometers. A Florida hospital developed the practice of placing Negroes in the basement unless they were "prominent" and one Mississippi facility has refused to permit Negroes to visit "white" wards. At many hospitals, when a Negro seeks admission he is required to show greater financial security than a white and is turned away if he does not demonstrate ability to pay. Although refusal to admit Negro emergency patients is said to be a thing of the past, an alarming number of seriously ill Negroes are refused hospital admission until a guarantor of their fees can be found. Segregation also means a gross disparity in physical conditions and professional services: a surprising number of southern hospitals force Negro patients—male and female—to use a single lavatory; and a common method of obtaining rooms for whites is to move Negro beds into hallways when the white section of the hospital has been filled. Negro patients complain of antiquated facilities, poor service and outright discourtesy from hospital personnel.¹⁵

Discrimination against Negro professionals is also prevalent. Negro physicians and dentists encounter difficulty in gaining free access to hospital staffs, forcing them to turn patients over to white physicians for hospitalization, much to their financial detriment, or to offer treatment in private clinics which cannot offer the facilities or services of government or community hospitals. The numerous professional and educational benefits of affiliation with the American Medical Association and American Dental Association are often privileges restricted to white practitioners.¹⁶ If a hospital employs Negro nurses (and many do not), they are rarely promoted to supervisory positions and are often paid less than white nurses for the same work.¹⁷ Despite a pressing national need, hospital-affiliated nursing schools still exclude Negroes or minimize their numbers and few southern hospitals train Negroes for expanding job opportunities in

¹⁵ The following practices of Atlanta's largest hospital were established in a federal court suit: exclusion of Negro physicians from medical staff; assignment of Negro patients to specified floors and rooms; separate clinics, rest-rooms, ambulance service; operation of segregated nursing schools; and exclusion of Negroes from medical technician training programs. *Bell v. Fulton-DeKalb Hosp. Authority*, Civil No. 7966, N.D. Ga., Feb. 23, 1965. Cf. U.S. COMM'N ON CIVIL RIGHTS, TITLE VI . . . ONE YEAR AFTER (1966).

¹⁶ Both organizations have adopted hortatory resolutions calling for nondiscriminatory admission policies on the part of constituent societies, but have resisted efforts to discipline the many affiliates who ignore them. As most county and state medical and dental societies, affiliated with AMA and ADA, participate in the selection of the state health officers who regulate their professions, admission policies are also subject to constitutional standards and successful suit for injunctive relief. *Hawkins v. North Carolina Dental Soc'y*, 355 F.2d 718 (4th Cir. 1966); *Bell v. Georgia Dental Soc'y*, 231 F. Supp. 299 (N.D. Ga. 1964).

¹⁷ Cf. *Smith v. Hampton Training School for Nurses*, 360 F.2d 577 (4th Cir. 1966) (Negro nurses discharged after protest of segregated cafeteria entitled to reinstatement and back pay).

technical fields, such as operation of X-ray machines and occupational and vocational therapy.¹⁸

The medical consequences of racial discrimination in health facilities and services are not easily traced, but it is likely that the patterns of discrimination described are in part responsible for high Negro infant mortality and lower average life expectancy.¹⁹ The costs in terms of discomfort, worry, humiliation and pain, loss of earnings and waste of human potential are nonetheless real for being immeasurable.²⁰

Discrimination in medical facilities generated only a small volume of litigation²¹ and little public attention²² until the 1963 decision of the Fourth Circuit in the landmark case of *Simkins v. Moses H. Cone Memorial Hospital*²³ established widespread hospital desegregation as an immediate goal of every civil rights organization. Between 1954 and 1962, two Greensboro, North Carolina, hospitals received approximately 3.2 million dollars from the United States in order to defray construction costs of facilities for new patient care and nurses' training.²⁴ Both refused treatment to Negroes desiring hospitalization and excluded Negro physicians and dentists from staff affiliation—a prerequisite to placement of patients in the hospital. Although the racial policies of both hospitals antedated receipt of federal funds, exclusion

¹⁸ These practices not only restrict the work opportunities of Negroes, denying to them significant educational and financial rewards, but also withhold from their communities the benefits of an increased number of trained professionals. The refusal of Negro doctors, for example, to accept the conditions of practice in the South has, over the last generation, reduced the number of Negro physicians in the region in proportion to Negro population, and aggravated an already acute shortage of physicians. See REITZES, *NEGROES AND MEDICINE* 272, 295, 316 (1958).

¹⁹ *Simkins v. Moses H. Cone Memorial Hosp.*, 323 F.2d 959, 970 n.23 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964); NATIONAL URBAN LEAGUE, *HEALTH CARE AND THE NEGRO POPULATION* (1965); PETTIGREW, *A PROFILE OF THE NEGRO AMERICAN* (1964); Fein, *An Economic and Social Profile of the Negro American*, 94 DAEDALUS 815, 817-24 (1965).

²⁰ A full explanation of the persistence of discrimination with such disturbing consequences would require an appraisal of resistance to equality in general as well as responses to threatened desegregation of health institutions. It is plain, however, that efforts to desegregate medical facilities, whether through persuasion or coercion implicit in use of legal processes, are opposed long after resistance appears impractical.

²¹ *Rackley v. Board of Trustees*, 310 F.2d 141 (4th Cir. 1962) (preliminary injunction inappropriate; remanded for trial); *Eaton v. Board of Managers*, 261 F.2d 521 (4th Cir. 1958), *cert. denied*, 359 U.S. 984 (1959) (insufficient "state action"; fourteenth amendment inapplicable); *Wood v. Hogan*, 215 F. Supp. 53 (W.D. Va. 1963) (Hill-Burton hospital not subject to fourteenth amendment); *Wood v. Vaughn*, 209 F. Supp. 106 (W.D. Va. 1962), *aff'd sub nom.* 321 F.2d 474 (4th Cir. 1963) (citizen-taxpayer has no standing to desegregate home for senile and aged).

²² Prior to 1964, federal law sanctioned racial discrimination in hospitals. The Public Health Service took the view that the nondiscrimination clause of the Hill-Burton Act, § 622, 60 Stat. 1041 (1946), as amended, 42 U.S.C. § 291c (1964), applied only to admission of Negro patients and the act itself expressly permitted waiver of the clause even as applied to admissions in cases of "separate facilities" approved for "separate population groups." See note 28 *infra*.

²³ 323 F.2d 959 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964).

²⁴ The funds received by Moses H. Cone Memorial and Wesley Long Hospitals amounted to approximately 15% and 50% respectively of the total cost of federally aided construction.

court also premised "state" and "federal action" on the Hill-Burton provision which enabled the Greensboro hospitals to avoid giving an assurance not to discriminate³² and declared the language which sanctioned segregation unconstitutional.³³

Simkins has not been restricted to hospitals authorized by Hill-Burton to exclude Negroes totally. A number of district courts have enjoined publicly owned and nongovernmental medical facilities from segregation³⁴ as well as exclusion of Negro patients and professionals.³⁵ The Fourth Circuit also extended the rule to a North Carolina hospital which was not a Hill-Burton grantee but, among other interrelations with government, had been forced to obtain a license because of the state's Hill-Burton participation.³⁶ Now that payments under the Medicare program have commenced, few medical facilities will be beyond the reach of the federal equity power.³⁷

particular projects within a state is governed by federal approved state plans. Hill-Burton Act § 623, 60 Stat. 1044 (1946), as amended, 42 U.S.C. § 291d (1964). See U.S. DEPT OF HEALTH, EDUCATION AND WELFARE, HILL-BURTON PROGRAM—PROGRESS REPORT, JULY 1, 1947—JUNE 30, 1961 (Public Health Service Pub. No. 880, 1961).

³² See note 28 *supra*.

³³ 323 F.2d at 969. The Supreme Court denied certiorari. 376 U.S. 938 (1964). As a result, the Surgeon General amended implementing regulations to require non-discriminatory admission and treatment of Negro patients and professionals in all Hill-Burton hospitals. 42 C.F.R. § 53.112 (1964). According to the United States Commission on Civil Rights, after the change in regulation sponsors of eight "separate but equal" facilities, whose projects were still in varying stages of construction, were required to execute nondiscriminatory assurances as a condition for continuing to receive federal funds. However, projects already completed and the 835 "nondiscriminatory" facilities under construction and receiving federal funds at that time were unaffected by this ruling. The Public Health Service asked sponsors of the facilities under construction to execute voluntary nondiscrimination assurances that staff privileges would be available to all professionally qualified persons. Sponsors of almost 700 of these facilities agreed to do so. Although the Service sought these assurances it did nothing to alter the prevailing southern unwillingness to implement the promises made in them. U.S. COMMISSION ON CIVIL RIGHTS, SPECIAL PUB. NO. 2 (1965).

³⁴ *Hayling v. Flagler*, 344 F.2d 950 (5th Cir. 1965); *Burton v. Arkansas Tuberculosis Sanatorium*, No. LR-66-C-51, E.D. Ark., May 3, 1966; *Pringle v. State Tuberculosis Bd.*, No. 1044, N.D. Fla., Jan. 26, 1966 (declaratory judgment); *Rackley v. Board of Trustees*, 238 F. Supp. 512 (E.D.S.C. 1965); *Rogers v. Druid City Hosp.*, 10 RACE REL. L. REP. 1273 (1965); *Batts v. Dublin Gen. Hosp.*, No. 1110, E.D.N.C., Dec. 22, 1965; *Lewter v. Lee Memorial Hosp.*, No. 65-47-Civ., M.D. Fla., Dec. 10, 1965; *Mangrum v. Iredell Hosp.*, No. 519, W.D.N.C., Nov. 9, 1965; *Hall v. Roanoke-Chowan Hosp.*, No. 522, E.D.N.C., Sept. 7, 1965; *Reynolds v. Anniston Memorial Hosp.*, No. 65-206, N.D. Ala., Jun. 21, 1965; *Bell v. Fulton DeKalb Hosp. Authority*, No. 7966, N.D. Ga., Feb. 23, 1965; *Clayton v. Person County Hosp.*, No. C-137-D-64, M.D.N.C., Oct. 28, 1964; *Addison v. High Point Memorial Hosp.*, No. C-96-C-64, M.D.N.C., Aug. 28, 1964; cf. *Porter v. North Carolina Bd. of Control*, No. C-123-D-62, M.D.N.C., Mar. 28, 1963 (pre-*Simkins* declaration of unconstitutionality of segregation in state mental institutions).

³⁵ Although Negro physicians have obtained full staff membership under the *Simkins* theory, the extent to which Negro professionals are protected when a hospital denies that exclusion has been racial presents troublesome questions which remain unresolved. See Note, *Working Rules for Assuring Nondiscrimination in Hospital Administration*, 74 YALE L.J. 151 (1964). The question is discussed in *Cypress v. Nonsectarian Hosp.*, 251 F. Supp. 667 (E.D. Va.), appeal docketed, No. 10672, 4th Cir., 1966.

³⁶ *Eaton v. Grubbs*, 329 F.2d 710 (4th Cir. 1964).

³⁷ Social Security Amendments of 1965, 79 Stat. 286 (1965) (codified in scattered sections of 26, 42, 45 U.S.C.). Under Medicare Insurance, payments are conditioned

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These actions have played a valuable role in eliminating specific instances of discrimination, but, when compared to the size of the problem, the number of Negroes affected by the cases is insignificant, the rate of change disappointing.³⁸ The impact of litigation has primarily been to fix public attention on the extent of the problem and the persistence of illegal segregation and its often startling consequences. By exposing injustices that have been buried from view and by educating and inspiring those who have attacked them, private litigation has helped to demonstrate the need for a nondiscrimination guarantee in federal programs and the need for an active role by the Department of Justice.³⁹ Continued use of litigation by Negroes attests to the inability of the federal government to implement that guarantee effectively, for although privately initiated federal court actions cannot themselves eliminate widespread and ingrained racial practices, they do demonstrate that inequality of treatment remains. Private efforts to desegregate medical facilities labor under extreme handicaps. In addition to a shortage of concerned litigants,⁴⁰ suffi-

upon a hospital meeting a variety of health and safety requirements and exercising its responsibility to discourage improper and unnecessary utilization of services and facilities. Social Security Amendments of 1965 § 1861(e), 79 Stat. 314 (1965), 42 U.S.C. § 1395x(e) (Supp. I, 1965). It would be difficult to distinguish *Simkins* and *Eaton* in a suit against a hospital premised on receipt of Medicare payments. As with Hill-Burton, federal funds under Medicare are disbursed to facilities which conform to federal standards in order to provide adequate hospital care to all persons within the statutorily defined class of aged.

³⁸ Private litigation in the best circumstances is costly and time consuming and a difficult means of changing the behavior of large numbers of persons playing a variety of roles. A privately initiated federal court suit for injunctive relief against a medical facility raises particular difficulties. The primary object of discrimination—the Negro patient—has but transient personal interest in or knowledge of the terms and conditions of treatment in local hospitals. At the time his interest is greatest—when he is ill—he is least likely to express interest in litigation. Negro physicians, dentists and nurses have litigated the legality of hospital practices, such as restrictive admission of professionals, but many are so successful within the confines of the segregated systems that they have little incentive to change it. Others lag behind the skills of better educated whites and hesitate to challenge racial barriers for fear their ability will be questioned. Others are unable to overcome the imposing evidentiary hurdle of proving they have been rejected for racial and not professional reasons. Indeed, it is so difficult for private litigants and a district court to police anything other than a nondiscriminatory admission policy that some hospitals have continued to discriminate notwithstanding decrees ordering desegregation. One of the hospitals involved in the *Simkins* case, Wesley Long of Greensboro, North Carolina, has yet to admit Negroes to its medical staff and, because white physicians will not admit their Negro patients, avoided desegregation.

³⁹ Managers of the Civil Rights Act of 1964 used *Simkins* to bolster their case for Title VI:

Title VI would override the "separate but equal" provisions now in the Hill-Burton Act. The policy of the Title might be enforced here by requiring the hospitals receiving Federal construction grants under the Hill-Burton Act [to] agree not to exclude or segregate patients, or otherwise discriminate in their treatment of patients, because of race, color or national origin. . . . Any such discrimination is unconstitutional under the decision of the U.S. Court of Appeals for the Fourth Circuit. *Simkins v. Moses H. Cone Memorial Hospital*, 323 F.2d 959 (C.A. 4, 1963), certiorari denied, March 2, 1964.

110 CONG. REC. 6546 (1964). See also 110 CONG. REC. 12720 (1964).

⁴⁰ See note 38 *supra*.

cient legal and investigative manpower is unavailable; only a fraction of the civil rights dollar may be committed to such litigation. It took two of Atlanta's four civil rights lawyers three years to desegregate that city's largest hospital. Throughout the suit they were hampered by an inability to learn the extent to which the hospital had modified, as it claimed, a variety of racial practices.⁴¹ Only investigative resources of the kind available to the federal government could have determined with any certainty whether the hospital had actually altered ingrained racial practices or was merely making a show of change while in litigation.

In theory, Title VI of the Civil Rights Act of 1964 transcends the limitations of privately initiated litigation by obligating the United States to require nondiscrimination as a precondition to federal assistance.⁴² Although complaints from private parties are authorized,⁴³ they are envisaged as ancillary⁴⁴ to the duty of federal administrators to require nondiscrimination as an integral part of the funding process.⁴⁵ Thus, the Department of Health, Education and Welfare early sought a written "assurance of nondiscrimination" from hospitals and other health institutions,⁴⁶ approval of which was necessary for receipt of financial assistance.⁴⁷ The Department quietly took the position, however, that execution of a facially satisfactory assurance would be accepted as sufficient unless victims of discrimination attacked the finding. A national survey of hospital discrimination announced by the Department was never carried out.⁴⁸ Actual (as

⁴¹ See note 15 *supra*.

⁴² 78 Stat. 252 (1964), 42 U.S.C. §§ 2000d to d2; 45 C.F.R. § 80.4 (Supp. 1966).

⁴³ 45 C.F.R. § 80.7(b) (Supp. 1966).

⁴⁴ "We cannot rely solely—or even primarily—on the filing of complaints by those who are the subjects of Title VI violations. The ultimate success of our Title VI efforts will in large measure depend on how effectively the responsible departments and agencies actually monitor compliance in the field." Letter From Attorney General Katzenbach to the Heads of Twenty-One Departments and Agencies With Title VI Responsibilities, December 27, 1965, on file in Biddle Law Library, University of Pennsylvania.

⁴⁵ "[E]ach department and agency with Title VI responsibilities should conduct regular, systematic inspections for possible discrimination to insure that the requirements of Title VI are in fact being observed by recipients of Federal assistance." *Ibid.* See 45 C.F.R. § 80.6 (Supp. 1966).

⁴⁶ The Public Health Service, Office of Education, Vocational Rehabilitation Administration, Welfare Administration and Social Security Administration administer over forty major programs of federal financial assistance to medical facilities. Some of the more prominent programs assist community health, community mental health centers, construction, students, research, vocational education and rehabilitation, families with dependent children and the aged, blind or disabled.

⁴⁷ 45 C.F.R. §§ 80.4, 80.8(b) (Supp. 1966). For the text of the assurance and the department's explanation, see 9 RACE REL. L. REP. 1960 (1964).

⁴⁸ Quigley, *Hospitals and the Civil Rights Act of 1964*, 57 J. NAT'L MED. ASS'N 455, 456-57 (1965).

opposed to promised) compliance was converted from a precondition to receipt of funds to a distant goal which the Department would actively seek only if it received a complaint.⁴⁹ Unfortunately, the Department's assumption that execution of a form eliminated entrenched discriminatory practices placed the burden to initiate compliance not on the orderly processes of government but on the fortuities of private circumstance. As of March 1, 1966, all but a fraction of the facilities⁵⁰ whose racial practices were brought to governmental attention⁵¹ in this manner had been investigated.⁵² The following table summarizes the performance of the Department:

TABLE I

TITLE VI PERFORMANCE OF
DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
JULY 2, 1964 THROUGH MARCH 1, 1966
MEDICAL FACILITIES

Potential Discriminators ⁵³	6,000
Refusal to File Nondiscrimination Assurance	100
Complaints Filed	350
Compliance Findings	100
Funds Cut Off ⁵⁴	0
Funds Withheld ⁵⁵	100

Table II illustrates the performance of the Department of Justice with respect to medical facilities during the same period:

⁴⁹ If such a construction were anything but the product of the most compelling administrative necessity, it would appear totally contrary to Title VI. For the belatedly issued views of the Attorney General, see notes 44 & 45 *supra*.

⁵⁰ Most of the facilities on the HEW docket are general hospitals, although a small number of complaints have been received with respect to nursing homes, clinics, health centers and long-term care institutions.

⁵¹ Sample complaints, filed in the name of organizations such as the NAACP, NAACP Legal Defense and Educational Fund, Inc. and the Medical Committee for Human Rights, briefly alleged the character of discriminatory practice, requested that the Department investigate and, if investigation substantiated allegations of discrimination, cut off funds. During the pendency of the investigation, it was requested that funds be withheld.

⁵² Quigley, *supra* note 48.

⁵³ Southern and border state medical facilities: hospitals, nursing homes, health centers, clinics, long-term care institutions.

⁵⁴ Excluding cut-off to facilities refusing to file satisfactory "Assurance of Non-discrimination."

⁵⁵ In at least 100 cases, funds have been withheld. Only approximate statistics are available.

TABLE II

CIVIL RIGHTS ACT SUITS INSTITUTED BY
DEPARTMENT OF JUSTICE ⁵⁶
JULY 2, 1964 THROUGH MARCH 1, 1966
MEDICAL FACILITIES

Potential Discriminators ⁵⁷	6,000
Title III	0
Title VI	0
Title IX ⁵⁸	0

Complaint-oriented administration, as Table I demonstrates, is a failure. It reaches but a fraction of potentially discriminating facilities and permits the remainder to continue racially discriminatory practices unchecked. Even with respect to those facilities reached by the complaint process, Title VI, as presently administered,⁵⁹ does not appear to have had a satisfactory impact.⁶⁰ Although Table I shows

⁵⁶ The number of complaints or referrals received by the Department is unknown.

⁵⁷ Southern and border state medical facilities.

⁵⁸ Intervention.

⁵⁹ As a complete statistical breakdown is unavailable, this article makes no attempt to examine or appraise the manner in which the Department of Health, Education and Welfare certified southern hospitals for participation in the Medicare program from May 1 through July 1, 1966. Although the Department made hundreds of site inspections during this period, regardless of whether or not complaints had been received, civil rights groups have been openly critical of the fact that only a fraction have been denied funds. The New Republic, Aug. 27, 1966, p. 8; N.Y. Times, July 28, 1966, p. 18, col. 1. Such criticism led the Surgeon General to order an investigation into the practices of eight Atlanta hospitals which had been cleared for Medicare, despite clear evidence that Negro physicians were still excluded and that white staff physicians were referring patients among hospitals on the basis of race. U.S. DEPT OF HEALTH, EDUCATION AND WELFARE, REPORT ON CIVIL RIGHTS COMPLIANCE, ATLANTA, GEORGIA HOSPITALS (1966).

⁶⁰ Ineffectual administration even with respect to facilities complained against is demonstrated by the following HEW report which describes one of a dozen cases where private litigation was required to desegregate a hospital violating Title VI:

This is in reference to the complaint filed by your organization against the Lee Memorial Hospital, Fort Myers, Florida. It was alleged that "Negroes are denied admission, except for surgery, and only then if a white physician requests their admission."

The Lee Memorial Hospital is a non-profit institution and consists of two units, the Lee Hospital and the Jones-Walker Hospital Annex. The latter provides hospital services only to non-whites while the Lee Memorial Hospital admitted white patients only. These facilities were first visited in July 1965 by representatives of the Department, and the violations contained in the complaint were verified. A subsequent visit in October 1965 revealed that to some extent the hospital authorities had taken steps to comply with Title VI. Notice was given to the community announcing the hospital's new desegregation policy and several Negro patients have been admitted to the Lee Memorial Hospital. However, unless requested by the physician, Negro patients were sent to the Jones-Walker Annex. On this basis, the Department was unable to find the hospital in compliance.

Subsequent to our second visit, several events occurred which affected the Lee Memorial Hospital. First the hospital was ordered by the U. S. District

that only one-third are in compliance with federal law, there has been no attempt to apply Title VI sanctions to the others. In at least 100 cases, most of which resulted in compliance findings, the Department has held up payment of funds pending determination of actual compliance from new applicants with respect to whom it has received complaints,⁶¹ but as most federal grantees receive payments

Court to cease its discriminatory practices at both hospitals, and second, the 40-bed addition to the Lee Memorial Hospital was completed. On January 15, 1966, the Negro patients in the Jones-Walker Annex were moved to the Lee Hospital and fully integrated with other patients. Again, on February 23, 1966, representatives of this office visited the hospital which revealed biracial room occupancy, nurses servicing both races, and admission policies reduced in writing. The Jones-Walker Annex has been closed and turned over to the County which will lease the property to the local school board.

Our review of these reports indicates that the hospital is now in compliance with the provisions of Title VI of the Civil Rights Act of 1964, and we are, therefore, removing it from the complaint list.

⁶¹ It may be instructive to consider the course of one of HEW's more successful applications of Title VI. On March 3, 1965, the NAACP Legal Defense and Educational Fund, Inc. and the NAACP complained that at the 375 bed Medical College Hospital, teaching hospital for the Medical College of South Carolina of Charleston, South Carolina, "Negroes are consistently placed in the east wing on the fifth and sixth floors where visiting hours are restricted to one hour a day. The sections of the hospital used by whites permit up to three hours a day for visiting."

On May 14, 1965, the regional office of HEW in Atlanta informed the administrator of the complaint and that a site review of hospital practices would be held. In preparation for this review, the regional director requested a listing of federal funds received by the hospital, and copies of its Title VI assurance of compliance and any written procedures, documents or circulars which related to compliance.

On May 21, 1965, the hospital superintendent replied generally to the letter of the regional director explaining that the allegations of the complaint with respect to visiting hours pertain to a distinction made between charity and paying patients: "It is a natural social phenomena that patients in the lower economic levels receive the most demands in hospitals. It is for this reason plus the fact that our teaching wards generally run a high census that we found it necessary to control and limit visitation on these particular wards." While it does not appear that the superintendent made the requested information available, he did provide a census for personnel which showed Negroes employed primarily as maids and porters.

On May 26, 1965, three departmental investigators met with hospital officials and proceeded to investigate the hospital's compliance with Title VI. They determined that the institution had been completed with the assistance of Hill-Burton funds and that the hospital received additional federal funds each year for vocational rehabilitation, patient care, crippled children, cancer and general research. On the day of the visit the hospital had 368 patients of which an estimated 150 to 160 were Negroes. Of the 100 medical doctors on the staff of the hospital there were no Negroes. The same was true for the 18 interns, 75 residents, 160 medical students and 180 school of nursing students.

At the visit, the Superintendent revealed that visiting hours had been standardized for all patients subsequent to the complaint. He also stated that a Negro female student had been admitted to the school of medicine and would be taught at the hospital.

The investigation discovered that the hospital used a local private hospital, the Roper Hospital, for services and medical student training and that Roper admits only white patients. It was also observed that no Negro patients had been admitted to the tenth floor of Medical College Hospital, the psychiatric facility. Other floors were integrated but only a small amount was noticed in semi-private rooms and wards. Although exceptions were noted, courtesy titles appeared to be employed generally. Evidence of Negro and white employees using different cafeterias was observed and it appeared that the hospital continued segregation by maintaining two facilities, one for pay patients and one for charity patients.

On June 15, 1965, on the basis of the investigators' report, the regional director telegraphed the President of the Medical College pointing up exclusion of Negroes

under continuing grant programs this practice is of limited application.⁶²

The Attorney General did not issue guidelines for the enforcement of Title VI until December 27, 1965.⁶³ These guidelines make clear that initial applications in the case of new or existing programs of continuing assistance may be deferred by an agency in order to assure nondiscrimination. Prior to their issuance legal officers of the Department had cast doubt on the authority of Title VI administrators to take such action prior to a full hearing. Although departmental personnel are reluctant to discuss their practice during the period prior to issuance of these guidelines when it appeared that deferral in order to obtain compliance might be illegal, an assessment of the Department's action with respect to complaints filed by the NAACP Legal Defense and Educational Fund, Inc. and the NAACP suggests that funds were withheld and applications deferred when an initial application was received from a facility on the complaint list and, haphazardly, from facilities not on the complaint list but applying for a grant under the Hill-Burton program. Because these deferrals took place under the shadow of a restrictive interpretation by department lawyers and because the Attorney General had not issued guidelines, documentation of the extent of such deferrals is not available.

An argument put forward to explain the failure of the Department to commence proceedings to terminate federal grants relies on the Civil Rights Act directive that no action be taken to apply Title VI sanctions until it has been "determined that compliance cannot be

from the psychiatric service, cafeteria policy and continued use of Roper Hospital for training and recommended that elimination of these conditions would enable him to recommend that the facility was in compliance. Two days later the President telegraphed the regional director that a Negro had been admitted to the psychiatric service, "positive pressures have been applied to mixing of races in both cafeterias" and Roper Hospital had been advised that relations would be severed.

Reading of the investigative reports makes clear that the prompt resolution of noncompliance was a consequence of the hospital's dependence on a series of annual federal grants, and prompt, vigorous prosecution by the regional director who repeatedly implied that funds would be cut if discrimination continued. Withholding of these funds, even for a short period, would have had serious consequences to a teaching hospital, for research and other grants enable it to attract and maintain a staff of residents and interns and to provide the services which make such hospitals centers of medical talent.

⁶² The Department has expressed a willingness to delay funds sought by applicants for initial grants until de facto nondiscrimination is assured because it can do so for a reasonable period without awaiting the outcome of administrative proceedings. 45 C.F.R. § 80.8(b) (Supp. 1966). This practice, however, has been rendered of little consequence by the decision to apply it only to facilities as to which complaints have been filed. An exception has been initial Hill-Burton Act grants where "non-discrimination" site visits have taken place when complaints have been filed in some but not all cases. The extent of the Department's willingness actually to deny funds to new applicants will be tested as thousands of southern hospitals, as to which complaints have not been received, begin to receive funds under the Medicare program. See note 59 *supra*.

⁶³ Guidelines for the Enforcement of Title VI Issued by Attorney General Katzenbach, December 27, 1965, on file in Biddle Law Library, University of Pennsylvania.

secured by voluntary means.”⁶⁴ Meaningful voluntary compliance and procedures calculated to obtain it are never to be scorned, especially with respect to medical facilities, since Title VI sanctions would deny funds to many institutions which require them to provide decent health services. Unfortunately, the moment administrators take voluntary compliance as an end in itself, rather than as an appropriate means of initially inducing nondiscrimination, manipulation of conciliation efforts quickly becomes a discriminator’s primary tactic for avoiding change. A reading of a departmental investigation file is revealing. After inspection verifies claimed discrimination, many hospitals formally reiterate their adherence to the terms of the original nondiscrimination assurance. Subsequent inspection by the Department, however, usually fails to show compliance. Of the first twelve hospitals which the NAACP Legal Defense and Educational Fund, Inc. and the NAACP brought to the attention of the Department (February 12, 1965), only four are now compliant.

Federal officials often complain that Title VI imposes procedural barriers to the use of sanctions, hurdles which, it is argued, frustrate attempts to force large numbers of facilities to comply with its terms.⁶⁵ The Department of Health, Education and Welfare, however, is in a poor position to complain of burdensome administrative hearings, at which it would be required to make a record of noncompliance, for the Department has not held any hearings involving medical facilities. More significantly, Title VI hearing requirements need not impede efforts to apply sanctions, if there is a will to apply them, in a reasonable number of cases. It is not readily apparent why the Department is unable to submit the reports of its investigators, along with such evidence as a grantee hospital wishes to submit, to a hearing officer. A finding of discrimination entered on the basis of such a record would in most cases, the factual issue of discrimination being reasonably clear cut, withstand judicial review.⁶⁶ Title VI procedures, with an exception discussed below, are similar to those which govern administrative adjudication throughout the federal government.⁶⁷ While the Department might not have the resources to proceed against every

⁶⁴ 78 Stat. 252 (1964), 42 U.S.C. § 2000d-1; 45 C.F.R. § 80.6(a) (Supp. 1966).

⁶⁵ Section 602 of the Civil Rights Act of 1964, 78 Stat. 252 (1964), 42 U.S.C. § 2000d-1 (1964), provides that “termination of or refusal to grant or to continue assistance” requires “an express finding on the record, after opportunity for hearing, or a failure to comply with such requirement” and “no such action shall become effective until thirty days have elapsed after filing” a “full written report of the circumstances and the grounds for such action” with the committee of the House and Senate having legislative jurisdiction over the program involved.

⁶⁶ Review of such a determination is authorized by the court of appeals for the circuit in which the facility is located. 78 Stat. 253 (1964), 42 U.S.C. § 2000d-2 (1964). See 60 Stat. 243 (1946), 5 U.S.C. § 1009 (1964).

⁶⁷ 60 Stat. 239 (1946), 5 U.S.C. §§ 1004-07 (1964).

facility which discriminated, the value of even a small number of such proceedings *pour decourager les autres* is obvious. As the matter stands, the deterrent force of Title VI is solely a matter of exhortation, for no one has been made to pay its penalty save the few facilities which refused initially to execute an assurance.

A far more likely explanation for the reluctance of the Department to refuse assistance because of continued discrimination is the Title VI requirement that a full written report of the circumstances and the grounds for such action be filed with the committees of the House and Senate having legislative jurisdiction over the program involved.⁶⁸ This novel provision invites pressures from Congress which federal bureaucrats are trained to avoid. The required notice to the very legislators who influence, if not determine, future congressional decisions with respect to the agency or department in question provides a powerful incentive to avoid a cut-off. In order to parry the inevitable criticism which a termination of assistance would entail, administrators require support within Congress and the higher levels of the Executive Branch. The failure of the Department to proceed against any health facility forces the conclusion that the necessary encouragement has been lacking.⁶⁹

Another reason which is given for the failure of the Department to impose the Title VI cut-off sanction on recalcitrant medical facilities is the extreme injury and dislocation which would be caused by terminating assistance. It is urged that Title VI sanctions are too powerful to accomplish their stated objective of nondiscriminatory operation of medical facilities. Much of the force of this position is dissipated by the absence of any program of court enforcement of Title VI. That is, if the termination of assistance is viewed as an unduly harsh sanction, one would expect administrators anxious to change patterns of discrimination to impose, at the very least, a more moderate means of forcing compliance. It is difficult, however, to accept the argument even with regard to termination of funds. When Title VI was first proposed, President Kennedy thought it drastic and rejected its use on this ground. But Congress in 1964 clearly considered this objec-

⁶⁸ 78 Stat. 252 (1964), 42 U.S.C. § 2000d-1 (1964).

⁶⁹ One need not challenge the good faith of the people who administer Title VI. They experience a real conflict in goals for no one wants to deny federal assistance to hospitals, but the extent to which discrimination defeats the usual goals of federal assistance is not fully understood. Discrimination denies the fruits of federal funds to those who need it most and impedes creation of the very social conditions in whose name most federal programs are justified. Finally, Title VI reflects the congressional judgment that recipients of federal assistance shall be obliged to carry out their functions without discrimination on the basis of race. Whatever may be said to justify the tolerance of such discrimination implicit in the failure of the Department to commence proceedings to terminate federal grants, it cannot be denied that this failure conflicts with Title VI itself.

tion and determined that assurance of equality was paramount to the uninterrupted flow of public assistance, at least in those cases where a meaningful conciliation process had proven unsuccessful.⁷⁰ Secondly, the deterrent effect of termination is largely untested. One would suppose that if cut-off is a drastic remedy, sparing but calculated use would foster change in a variety of institutions. As the matter stands, total failure to apply these sanctions has created a vacuum where facially unmistakable provisions of federal law have been effectively repealed by a political and administrative process largely invisible to the public.

The alternative sanction available to enforce Title VI is litigation. Whatever "political" or other excuses there may be for reluctance to terminate or withhold assistance do not apply to action in the courts because the Attorney General may compel nondiscrimination without interrupting the flow of funds.⁷¹ Judicial enforcement of Title VI also avoids the procedural requirements necessary for termination of assistance but does present problems of its own. The Attorney General can only maintain a limited number of such suits at any one time and prompt relief is more likely the exception than the rule. Still, actions against flagrant violators of Title VI and large community institutions would accomplish a great deal of actual desegregation because a series of such suits would have an inevitable deterrent effect. However restricted the manpower available to the Civil Rights Division of the Department of Justice the fact remains that during the period under discussion (July 2, 1960—March 1, 1966), the NAACP Legal Defense and Educational Fund, Inc., a private legal aid organization, maintained approximately thirty-five actions against southern medical facilities. When the record of inaction reflected by Table II is compared with the broad statutory authority of the Department,⁷² the conclusion is irresistible that the absence of political support for application of Title VI sanctions observed with respect to denial of assistance has thwarted even the relatively mild remedy of enforcement litigation.

⁷⁰ See note 6 *supra*.

⁷¹ The Attorney General may use one of the following devices:

1. Suit to obtain specific enforcement of assurances, covenants running with federally provided property, statements of compliance or desegregation plans filed pursuant to agency regulations.
2. Suit to enforce compliance with other titles of the 1964 act, other civil rights acts or constitutional or statutory provisions requiring nondiscrimination.
3. Initiation of, or intervention or other participation in, a suit for other relief designed to secure compliance. Guidelines for Enforcement of Title VI Issued by Attorney General Katzenbach, December 27, 1965, on file in Biddle Law Library, University of Pennsylvania. See 45 C.F.R. § 80.8 (Supp. 1966).

⁷² See note 71 *supra*.

It is apparent that Title VI is potentially a powerful engine of social change, capable of modifying a great many of the discriminatory conditions faced by the southern Negro. As a device for elimination of discrimination in southern medical facilities, Title VI is especially promising since few of the region's health institutions are independent of federal contribution. Starting from this premise, we have reviewed some justifications put forth for the failure of government to make other than minor use of Title VI sanctions in the face of overwhelming evidence that racial discrimination in health continues unabated. None appears to account for the absence of enforcement activity, suggesting, therefore, a failure of political support. Although this is not the place for speculation about the character or cause of the lack of encouragement for Title VI enforcement, it is apparent that more attention must be paid to the implementation of desirable civil rights principles subsequent to their enactment into law. Insufficient scrutiny by the Department of Health, Education and Welfare and the Department of Justice has in part permitted the reported practices to go largely unchallenged until accomplished fact. Uncertainty as to who makes or unmakes the critical decisions, and when they are made, is a serious block to understanding and thus to change. Unless we demand more from the political and administrative processes charged to implement principles of equality, proscribed discrimination will continue, a condition which imperils the "existence of government" itself.⁷³

⁷³ *Olmstead v. United States*, 277 U.S. 438, 485 (1928) (Brandeis, J., dissenting).